FILED
U. S. DISTRICT COURT
DISTRICT OF NEBRASKA

2012 NOV 27 PM 3:20

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

PRO SE CIVIL COMPLAINT

Case No. 4:12CV3234
(the court will assign a number)

I. CASE CAPTION: Parties to this Civil Action:

Pursuant to Fed. R. Civ. P. 10(a), the names of all parties must appear in the case caption. The court will not consider a claim against any defendant who is not listed in the caption.

A. **Plaintiff(s) Name(s):** **Address(es):** **Telephone No. (only if you are NOT a prisoner)**

TROY L. JONES 4820 SHERMAN LINCOLN, NE 68506. Victim

B. **Defendant(s) Name(s):** **Address(es) If known:**

MARY L. HESSER, 300 WIST, CORTLAND NE 68331.

LAURA TAGUE, STATE FARM CLAIMS P.O. BOX 52273 PHOENIX, AZ 85072-2273 PHONE # (800) 889-7144-EXT. 5975557 STATE FARM. CLAIM REPRESENTATIVE STATE FARM etal..

(Attach extra sheets if necessary.)

II. STATEMENT OF CLAIM(S)

State briefly the facts of your claim. Describe how each defendant is involved. You do not need to give legal arguments or cite cases or statutes. Use as much space as you need to state the facts. (Attach extra sheets if necessary.)

A. **When** did the events occur?

THE ALLEGED INCIDENT OCCURRED APPROXIMATELY 16:54p.m ON AUGUST-23-2012. I WAS TRAVELING EASTBOUND ON NORMAL BLVD SOUTH 40TH.

B. **What** happened?

PLAINTIFF MR. JONES. WAS DRIVING EASTBOUND ON 40TH & NORMAL BLVD. APPROACHING THE INTERSECTION AT APPROXIMATELY 30 M.P.H. STAYING IN MY LINE. THE LIGHT WAS GREEN I NOTICED A VEHICLE COMING WESTBOUND AT AN EXTREEMLY RECKLESSLY FAST SPEED THE VEHICLE WAS DRIVEN BY THE DEFENDANT, MARY L. HESSER IN VERY NEGLIGENT MANNER. SHE WAS NOT EXERCISING RESONABLE CARE. DEFENDANT'S FAILURE TO USE RESONABLE CARE. THE DEFENDANT NEGLIGENTLY OPERATED THE VEHICLE BY CRASHING INTO PLAINTIFF

II. STATEMENT OF CLAIM(S) (continued)

CAR CAUSING PERMANENT INJURIES THAT WAS SUSTAINED. THE DEFENDANT WAS GIVEN A TRAFFIC TICKET by THE LINCOLN POLICE DEPARTMENT. THE DEFENDANT'S NEGLIGENCE WAS A PROXIMATE CAUSED TO THE PLAINTIFF'S SUSTAINED INJURIES. That will LAST A LONG, LONG TIME EVEN AFTER A SETTLEMENT IS MADE. THE DEFENDANT LAURA TAGUE A CLAIM RESPENSENTATIVE FOR STATE FARM ISSURANCE, Admitted TO THE PLAINTIFFS INJURIES, BUT disputed THE EXTENT OF his INJURIES. That is 2,000,000.00 INJURY. ALL EXhibits ARE ATTACHED HERETO.

III. STATEMENT OF JURISDICTION

Check any of the following that apply to this case (you may check more than one):

X United States or a federal official or agency is a party

X Claim arises under the Constitution, laws or treaties of the United States

X Violation of civil rights

_____ Employment discrimination

X Diversity of Citizenship (a matter between citizens of different states in which the amount in controversy exceeds $75,000)

_____ Other basis for jurisdiction in federal court (explain below)

COMES NOW THE PLAINTIFF TROY JONES PROSE AND THIS COURT HAS JURISDICTION. STATE FARM IS LOCATED IN WEST CENTRAL ACC P.O. BOX 52273. PHOENIX. AZ 85072-9708, IN THE ABOVE EN-TITLED CAUSE OF ACTION.

IV. STATEMENT OF VENUE

State briefly the connection between this case and Nebraska. For example, does a party reside or do business in Nebraska? Is a party incorporated in Nebraska? Did an injury occur in Nebraska? Did the claim arise in Nebraska?

DEFENDANT LAURA TAGUE AGENT IS EMPLOYED AND RESIDE IN NEBRASKA. STATE FARM CLAIMS P.O. BOX 52273 RESIDES IN PHOENIX AZ. 85072-2273. THE SETTLEMENT PAYMENTS WILL BE ISSUED FROM.

V. RELIEF

State briefly what you want the court to do for you.

PLAINTIFF WANTS THE DEFENDANTS TO PAY HIM FOR THE SUSTAINED INJURIES THE AMOUNT OF 200,000.00, DEEM JUST AND EQUITIBLE,

VI. EXHAUSTION OF ADMINISTRATIVE PROCEDURES

Some claims, but not all, require exhaustion of administrative procedures. Answer the questions below to the best of your ability.

A. Have the claims which you make in this civil action been presented through any type of administrative procedure within any state or federal government agency?

Yes ✓ No _____

B. If you answered yes, state the date your claims were so presented, how they were presented, and the result of that procedure:

SEE EX. 001

C. If you answered no, give the reasons, if applicable, why the claims made in this action have not been presented through administrative procedures:

SEE. EX 001 EX. 002 EX 003 EX. 004 EX. 005

VII. ARE YOU REQUESTING TRIAL BY A JURY OR BY A JUDGE? (check one):

JURY X JUDGE _____

VIII. VERIFICATION

I (we) declare under penalty of perjury that the foregoing is true and correct.

Date(s) Executed: 11-27-12

Signature(s) of Plaintiff(s): Tracy Jones

Note:

IF YOU CANNOT AFFORD TO PAY THE COURT'S FILING FEE UPON THE FILING OF YOUR COMPLAINT, THERE IS A SEPARATE FORM TO BE USED FOR APPLYING TO PROCEED IN FORMA PAUPERIS. Also, if there is more than one plaintiff in the case who wishes to proceed in forma pauperis, **each such plaintiff must submit a separate application to proceed in forma pauperis.**

EX 001

Providing Insurance and Financial Services
Home Office, Bloomington, IL

StateFarm™

October 01, 2012

Troy Jones
4820 Sherman St
Lincoln NE 68506-3960

State Farm Claims
PO Box 52273
Phoenix AZ 85072-2273

This ✓

2,000.00
20,000.00
200,000.00

RE: Claim Number: 27-10X4-844
Date of Loss: August 23, 2012
Our Insured: Mary L Hesser
Claimant Name: Troy Jones

Dear Mr. Jones:

Thank you for your cooperation in presenting your claim for damages sustained in the above referenced accident. We have had the opportunity to fully investigate this loss and have made a decision regarding liability.

In the state of Nebraska, the laws are such that a person's damages may be reduced by the amount of negligence that they contribute to an accident. We feel you were negligent for failure to take proper caution while entering an intersection on a yellow light, which resulted in a collision with our insured's vehicle.

For this reason, we are offering to pay for 80% of the damages you sustained to your vehicle as well as 80% of your injury claim.

If you feel you need to discuss our liability decision, please feel free to call. Thank you.

Sincerely,

Laura Tague

Laura Tague
Claim Representative
(800) 889-7144 Ext. 5975557
Fax: (800) 423-0474

State Farm Mutual Automobile Insurance Company

Enclosure: none

EX 005

StateFarm™

Medical Provider/Employer Information

Claim Number: 27-10X4-844			
Name: Troy Jones			
Address: 4820 Sherman St			
City: Lincoln	State: NE	ZIP Code: 68506-3960	Phone: 402-416-0011
Ambulance? ☐ Yes ☐ No	Company Name:		
Emergency Room? ☐ Yes ☐ No	X-Rays? ☐ Yes ☐ No	Hospital Admission? ☐ Yes ☐ No	Number of Days:
Name and Address of Hospital:			
Primary Care Physician: THOMAS BAUER D.C.	Address and Phone Number:		
Physical Therapy? ☐ Yes ☐ No	Name of Facility:		
Address and Phone Number:			
Chiropractic Care? ☒ Yes ☐ No	Name of Facility: SOUTH LINCOLN CHIROPRACTIC , LINCOLN, NE 68502		
Address and Phone Number: 3201 PIONEERS BLVD. #32 402-484-8500			
Health Insurance Provider:			Policy Number:
Address (City, State, ZIP Code):			Phone Number:
Auto Insurance Carrier of Other Driver (if applicable):			Claim Number:
Address (City, State, ZIP Code):			Phone Number:
Medicare? ☐ Yes ☐ No	HIC #:	Medicaid? ☐ Yes ☐ No	DCN #
Name of Employer:			Phone Number:
Address (City, State, ZIP Code):			
Any time missed from work? ☐ Yes ☐ No	If yes, give dates and times:		
Describe job title and duties:			

If there are additional providers you have seen or work comp involved, please add the information on the back of this form.

08-2011

Ex002

StateFarm™

Medical Provider/Employer Information

Claim Number: 27-10X4-844			
Name: Troy Jones			
Address: 4820 Sherman St			
City: Lincoln	State: NE	ZIP Code: 68506-3960	Phone:
Ambulance? ☐ Yes ☐ No	Company Name:		
Emergency Room? ☐ Yes ☐ No	X-Rays? ☐ Yes ☐ No	Hospital Admission? ☐ Yes ☐ No	Number of Days:
Name and Address of Hospital:			
Primary Care Physician:	Address and Phone Number:		
Physical Therapy? ☐ Yes ☐ No	Name of Facility:		
Address and Phone Number:			
Chiropractic Care? ☐ Yes ☐ No	Name of Facility:		
Address and Phone Number:			
Health Insurance Provider:			Policy Number:
Address (City, State, ZIP Code):			Phone Number:
Auto Insurance Carrier of Other Driver (if applicable):			Claim Number:
Address (City, State, ZIP Code):			Phone Number:
Medicare? ☐ Yes ☐ No	HIC #:	Medicaid? ☐ Yes ☐ No	DCN #
Name of Employer:			Phone Number:
Address (City, State, ZIP Code):			
Any time missed from work? ☐ Yes ☐ No	If yes, give dates and times:		
Describe job title and duties:			

If there are additional providers you have seen or work comp involved, please add the information on the back of this form.

State Farm™

Authorization – Medical/Employment

Note: This authorization meets the core elements criteria set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule, Section 164.508(c).

Medical Provider:

Name of Injured Person: Troy Jones (hereinafter referred to as the "Injured Person")

Social Security Number of Injured Person: 587 23 0547 (needed to locate records)

Date of Birth of Injured Person: 1/3/62 (needed to locate records)

State Farm Claim Number: 27-10X4-844

I authorize:

(1) any medical, psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home, or any other healthcare facility to disclose information from the medical and healthcare records of the Injured Person. I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information; and

(2) any firm, employer, or insurance company to furnish information about the earnings, loss of earnings, work history, workers' compensation claim, and other medical information in its/their possession concerning the Injured Person, as well as, Event Data Recorder (EDR) information, photographs and other information about the physical damage to the vehicle(s) involved in the accident; and

(3) any educational organization to furnish the school records of the Injured Person to:

State Farm Mutual Automobile Insurance Company, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as "State Farm").

I authorize the use of the above information to permit State Farm to investigate, process, and determine the amount payable, if any, for all claims made under any State Farm property and casualty insurance policy that applies to the accident or occurrence on 8/23/2012. I understand as part of the claim handling process, State Farm may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professionals for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be re-disclosed and may not be protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that State Farm has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claims(s).

This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act for the purposes noted above. I understand that I may obtain a copy of this authorization upon written request submitted to State Farm.

Click here to enter text.

Date: 10-17-12

Troy Jones

Signature of individual or personal representative

Description of personal representative's authority or relationship to patient

04-2011

Ex 003.

SOUTH LINCOLN CHIROPRACTIC
INITIAL TREATMENT PLAN

Patient Name Jones, Troy

Date: 8-27-12

Diagnosis:

Treating Catagorical DX 847.0 739.1 739.3 728.85

Treating Subluxation DX C3-thru C7, T1, L5

GOALS OF TREATMENT To Attain MMI

RECOMMENDED TREATMENT PLAN (ESTIMATE)

Relief/ Therapeudic Phase :

Daily visits every week for 1-2 weeks.

3 visits every week for 3-4 weeks.

Rehabilitative/Supportive Phase: Then Re-evaluate

_____ visits every week for _____ weeks.

_____ visits every week for _____ weeks.

BE ADVISED NO MAINTENANCE CARE WILL BE PROVIDED

Additional Information: _____

Doctor's Signature Dr Thomas L. Baker Date 8/27/12

PHYSICAL, NEUROLOGICAL AND ORTHOPEDIC EXAM

Patient's Name Jones, Troy No. INMATE Date 8-27-12

	L	R
Triceps R.		
Biceps R.		
Radial R.		
Pupillary R.		
Tuning F.		
Fing. to Nose		
Froment's		
Form. Comp.		
Adson's		
Sh. Dep.		

	L	R
Patellar		
Achilles		
Rombergs		
St. Leg Raiser		
Ilium High		
Sh. High		
L. Curve		
T. Curve		
C. Curve		
Adam's		
Toe In		
Toe Out		

Cerv. Motion	N	Exam	Pain
Flexion	65	28	
Extension	50	38	
L. Rot.	85	51	
R. Rot.	85	42	
L. L. Flex	40	22	
R. L. Flex	40	24	

w/ Dizziness

Dorso-Lumbar Motion			
Flex.	95	56	
Ext.	35	36	
L. Rot.	35	33	
R. Rot.	35	28	
L. L. Flex.	40	37	
R. L. Flex.	40	36	

Low Back Pain

Dynamometer

L	R

B.P. ___/___
Pulse ___
Urine ___
Wt. ___
Ht. ___

1. Olfactory	8. Acoustic
2. Optic	9. Gagitaste
3. 4. 6. Eye Mus.	10. Swallow
5. Trigem.	11. Shrug
7. Facial	12. Tongue

Leg & Arm Size	L	R
Appar. Short		
True Short		
Thigh Mus.		
Calf Mus.		
Biceps Mus.		
Forearm		
Chest Expand		

Lungs
Percussion
Auscultation

Abdomen
Percussion
Palpation
Masses

	L	R
Der. Hip		
Eli Test		
Goldwaith		

Neck & Low Back

Remarks
Neck Pain & Low Back (R) Radial pain

	L	R
Laseques		
Braggards		
Leg Raise		
Leg Lower		
F. Patrick		
Soto Hall		

Neck & Low Back

Doctor's Signature

SOUTH LINCOLN CHIROPRACTIC
X-RAY REPORT

Patient Name Jones, Troy Age: 50 Date: AUG 27 2012

Reason for X-Ray Auto Accident of 8/23/12

Views Taken: Full Spine 2 Cervical 5 Thoracic ____ Lumbar ____
X-Rays taken at: SOUTH LINCOLN CHIROPRACTIC

PRIMARY FINDINGS:
Normal Study ____ No recent Fractures or Dislocations ✓
Soft Tissues Normal ____ No Active Organic Pathology ✓

MISCELLANEOUS FINDINGS:
Metallic Artifacts Present ✓ Phlebolithes Present ____ Abdominal Plaquing ____
Hemangioma ____ Osteoblastic Activity ____ Osteolytic Activity ____

OTHER FINDINGS: ____

DJD: SEEN AT THE: ~~CERVICAL~~ – THORACIC – LUMBAR REGIONS.
(MILD) MODERATE - ADVANCED AT LEVEL: CERVICAL
(DJD:) SEEN AT THE : CERVICAL - THORACIC - LUMBAR REGIONS.
(MILD) MODERATE - ADVANCED AT LEVEL: LUMBAR

CURVES: CERVICAL - NORMAL ____ HYPO ✓ HYPER ____
THORACIC- NORMAL ____ HYPO ____ HYPER ____
LUMBAR - NORMAL ____ HYPO ____ HYPER ____
PRIMARY CURVE – SECONDARY CURVE – TERTIARY CURVE
LEG LENGTH ____ INSTABILITY: NONE ____ MILD ____ SEVERE ____
GEORGES LINE: NORMAL ____ BROKEN AT: ____

SUBLUXATIONS AT: C2 thr C7, T1 & L4
IMPRESSIONS: 1. Loss of the cervical curvature
3. Multiple spinal subluxations

RECOMMEND: ~~Treatment~~ Therapy ~~for~~ ORDER: MRI - CT - BONE SCAN - NUCLEAR STUDY

SIGNED Dr [illegible] DATE: AUG 27 2012

PHYSICAL, NEUROLOGICAL AND ORTHOPEDIC EXAM

Patient's Name Jones, Troy No. Update Date 10/3/12

	L	R
Triceps R.	++	++
Biceps R.	++	++
Radial R.	++	++
Pupillary R.		
Tuning F.		
Fing. to Nose		
Froment's		
Form. Comp.		
Adson's		
Sh. Dep.		

	L	R
Patellar	++	++
Achilles	++	++
Rombergs	Neg	
St. Leg Raiser		
Ilium High		
Sh. High		
L. Curve		
T. Curve		
C. Curve	Pos	
Adam's	Neg	
Toe In		
Toe Out		

Cerv. Motion	N	Exam	Pain
Flexion	65	52	
Extension	50	70	
L. Rot.	85	71	
R. Rot.	85	61	
L. L. Flex	40	37	
R. L. Flex	40	41	

Very slight pain

Dorso-Lumbar Motion

Flex.	95	69	
Ext.	35	38	
L. Rot.	35	37	
R. Rot.	35	34	
L. L. Flex.	40	40	
R. L. Flex.	40	41	

Dynamometer

L	R

B.P. /
Pulse
Urine
Wt.
Ht.

1. Olfactory	Neg
2. Optic	
3. 4. 6. Eye Mus.	
5. Trigem.	
7. Facial	
8. Acoustic	Neg
9. Gagitaste	
10. Swallow	
11. Shrug	
12. Tongue	

Leg & Arm Size	L	R
Appar. Short	Neg	
True Short		
Thigh Mus.		
Calf Mus.		
Biceps Mus.		
Forearm		
Chest Expand		

Lungs
Percussion Neg
Auscultation

Abdomen
Percussion
Palpation
Masses

Remarks Pt making excellent progress.

	L	R
Der. Hip	Neg	
Eli Test		
Goldwaith		

	L	R
Laseques	Neg	
Braggards		
Leg Raise		
Leg Lower		
F. Patrick	Pos	
Soto Hall	Pos	

LB slight

Doctor's Signature

S0UTH LINCOLN CHIROPRACTIC
UPDATE X-RAY REPORT

Patient Name Jones Troy Age: 50 Date: 10/3/12

Reason for X-Ray Auto Accident of 8/23/12.

Views Taken: Full Spine ____ Cervical 4 Thoracic ____ Lumbar 2
X-Rays taken at: SOUTH LINCOLN CHIROPRACTIC

PRIMARY FINDINGS:
Normal Study ____ No recent Fractures or Dislocations ✓
Soft Tissues Normal ____ No Active Organic Pathology ✓

MISCELLANEOUS FINDINGS:
Metallic Artifacts Present ✓ Phlebolithes Present ____ Abdominal Plaquing ____
Hemangioma ____ Osteoblastic Activity ____ Osteolytic Activity ____

OTHER FINDINGS: ____

DJD: SEEN AT THE: (CERVICAL) – THORACIC – LUMBAR REGIONS.
MILD - MODERATE - ADVANCED AT LEVEL: ____
DJD: SEEN AT THE : CERVICAL - THORACIC - LUMBAR REGIONS.
MILD -MODERATE - ADVANCED AT LEVEL: ____

CURVES: (CERVICAL) - NORMAL ____ HYPO ✓ HYPER ____
THORACIC- NORMAL ____ HYPO ____ HYPER ____
LUMBAR - NORMAL ____ HYPO ____ HYPER ____
PRIMARY CURVE – SECONDARY CURVE – TERTIARY CURVE
LEG LENGTH 1/16 INSTABILITY: NONE ____ MILD ____ SEVERE ____
GEORGES LINE: NORMAL ____ BROKEN AT: ____

SUBLUXATIONS AT: C2 & L5
IMPRESSIONS: 1. Loss of Cervical Curve (But Improved)
3. Multiple Subluxations
RECOMMEND: ____ ORDER: MRI - CT - BONE SCAN - NUCLEAR STUDY

SIGNED [signature] DATE: 10/3/12

SOUTH LINCOLN CHIROPRACTIC
UPDATE TREATMENT PLAN

Patient Name JONES, TROY

Date: 10-3-12

Diagnosis:

Treating Catagorical DX 739.1 739.3

Treating Subluxation DX C3 L5

GOALS OF TREATMENT to ATTAIN MMI

RECOMMENDED TREATMENT PLAN (ESTIMATE)

Relief/ Therapeudic Phase :

1 visits every week for 2-3 weeks.

_____ visits every week for _____ weeks.

Rehabilitative/Supportive Phase:

_____ visits every week for _____ weeks.

_____ visits every week for _____ weeks.

BE ADVISED NO MAINTENANCE CARE WILL BE PROVIDED

Additional Information: _____

Doctor's Signature Dr Thomas LeRoux Date 10/3/12

StateFarm™

Medical Provider/Employer Information

Claim Number: 27-10X4-844			
Name: Troy Jones			
Address: 4820 Sherman St			
City: Lincoln	State: NE	ZIP Code: 68506-3960	Phone: 402-416-0011
Ambulance? ☐ Yes ☐ No	Company Name:		
Emergency Room? ☐ Yes ☐ No	X-Rays? ☐ Yes ☐ No	Hospital Admission? ☐ Yes ☐ No	Number of Days:
Name and Address of Hospital:			
Primary Care Physician: THOMAS BAUER D.C.	Address and Phone Number:		
Physical Therapy? ☐ Yes ☐ No	Name of Facility:		
Address and Phone Number:			
Chiropractic Care? ☒ Yes ☐ No	Name of Facility: SOUTH LINCOLN CHIROPRACTIC LINCOLN, NE 68502		
Address and Phone Number: 3201 PIONEERS BLVD. #32 402-484-8500			
Health Insurance Provider:			Policy Number:
Address (City, State, ZIP Code):			Phone Number:
Auto Insurance Carrier of Other Driver (if applicable):			Claim Number:
Address (City, State, ZIP Code):			Phone Number:
Medicare? ☐ Yes ☐ No	HIC #:	Medicaid? ☐ Yes ☐ No	DCN #
Name of Employer:			Phone Number:
Address (City, State, ZIP Code):			
Any time missed from work? ☐ Yes ☐ No	If yes, give dates and times:		
Describe job title and duties:			

If there are additional providers you have seen or work comp involved, please add the information on the back of this form.

SOUTH LINCOLN CHIROPRACTIC

PATIENT PAIN- INJURY- SENSATION FORM

Name (Please Print) Troy Jones Date AUG 2 7 2012

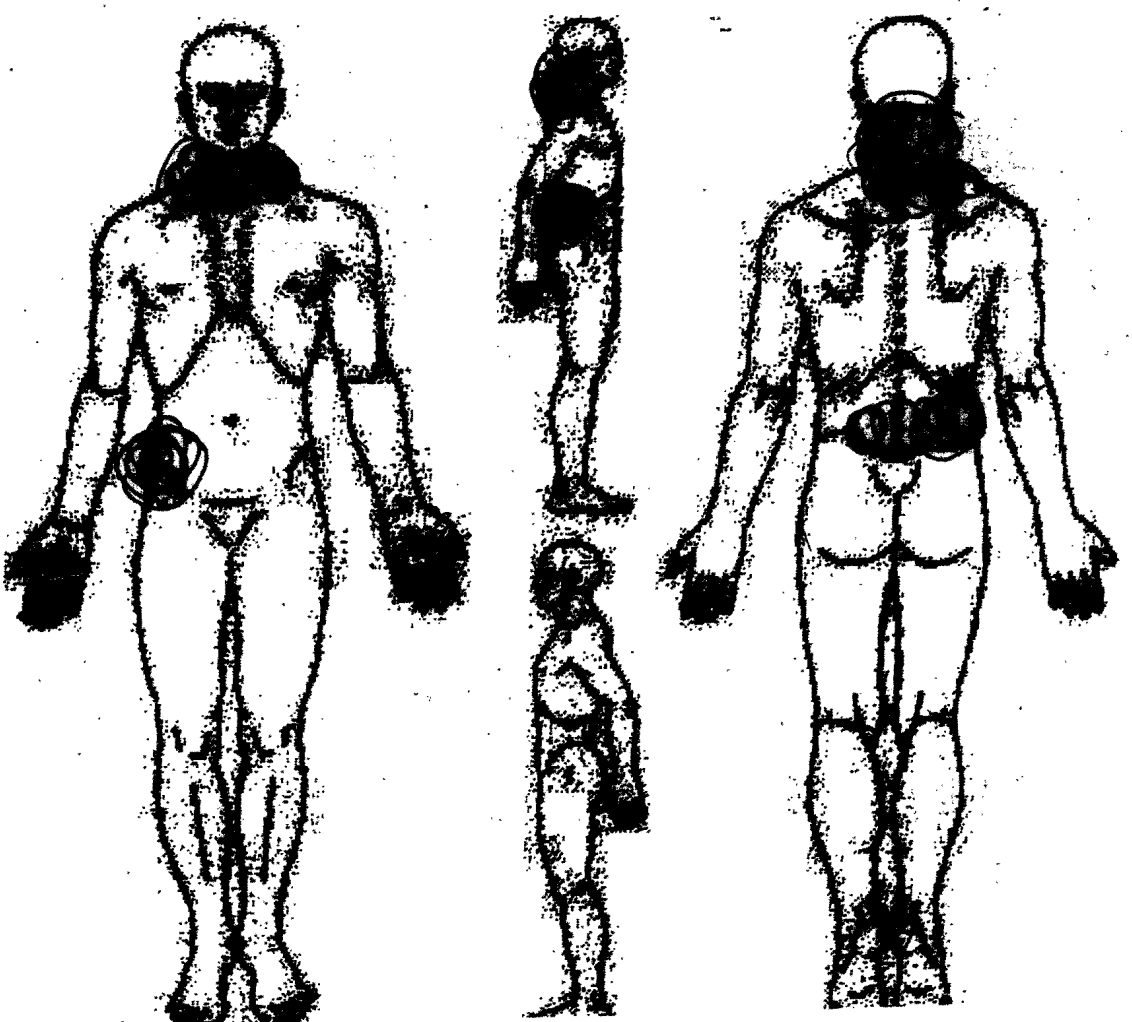
Age: 50 Date of Birth: 1-3-62 Occupation: _____

How long have you had the pain? ___ Years ___ Months days X No

Is this your first episode? X Yes ___ No

Use the letters below to indicate the type and location of your sensations right now

A=ACHE B=BURNING N=NUMBNESS
P=PINS & NEEDLES S=STABBING O=OTHER



PERSONAL INJURY REPORT

Name Troy Jones Date AUG 27 2012

Date of Accident Aug 23, 2012 Time ___ am 4:57 pm Location of Accident 40th & NORMAL

Describe how the accident occurred CAR turned in front of me in the intersection.

Were You: (X) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side (X) Front ( ) Parked

Did your car strike the others involved: ( ) Yes (X) No ( ) Undetermined

Was a traffic citation issued to : ( ) You (X) Other Driver ( ) Both ( ) No One

****

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

(X) Headaches	(X) Sleeping Problems	( ) Lights Bother Eyes	( ) Diarrhea
(X) Neck Pain	(X) Head Too Heavy	( ) Loss of Memory	( ) Feet Cold
(X) Neck Stiff	(X) Pins & Needles in Arms	( ) Ears Ring	( ) Stomach Upset
( ) Dizziness	( ) Pins & Needles in Legs	( ) Face Flushed	( ) Constipation
(X) Back Pain	( ) Numbness in Fingers	( ) Buzzing in Ears	( ) Cold Sweats
( ) Nervousness	( ) Numbness in Toes	( ) Loss of Balance	( ) Fever
(X) Tension	( ) Shortness of Breath	( ) Fainting	( ) Hands Cold
( ) Chest Pain	( ) Depression	( ) Loss of Smell	( ) Other
( ) Irritability	( ) Fatigue	( ) Loss of Taste	

Did you require post-accident hospitalization? ( ) Yes ( ) No

If Yes, Where ___

Have you lost any days of work? ( ) Yes (X) No If Yes, ___ through ___

INSURANCE INFORMATION

( ) Your Insurance Company FARM BUREAU Address ___

( ) Other Parties Name MARY HESSER Address ___

( ) Other Parties Ins. Co. STATE FARM INS. Address ___

Have you been contacted by an insurance adjustor regarding this claim: ( ) Yes (X) No

( ) If Yes, name of adjustor ___ Company ___

Do you have an attorney that has advised you in this case: ( ) Yes (X) No

( ) If Yes, name of attorney ___ Phone ___

PLEASE CHECK THE APPROPRIATE BOX(ES) INDICATING WHERE BILLS SHOULD BE SENT

AUG 27 2012 Signature* Troy Jones

CHIROPRACTIC CASE HISTORY

23 pg
TGB

CONFIDENTIAL PATIENT INFORMATION DATE AUG 2 7 2012

Name I Roy Jones Social Security 537 23 9447 Home Phone 402-416-0011

Address 4820 SHERMAN City LINCOLN State NE Zip 68506

Age 50 Birth Date 1-3-62 Marital: M S W D , How Many Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Husband or Wife _____ Occupation _____

Employer _____ Address _____

Name of Nearest Relative _____ Address _____ Phone _____

Referred by SELF

Is the condition due to injury or sickness arising out of employment? No
Is the condition due to injury or sickness arising out of auto or other accident? yes
Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition: Yes____ No____ If yes, when and describe _____

Date of last physical examination _____ Are you pregnant?
What operations have you had? _____ When? _____
Serious illnesses _____ When? _____

Have you ever suffered from:

1. Dizziness: _____
2. Backaches: _____
3. Heart Trouble: _____
4. Diabetes: _____
5. Hernia: _____
6. Arthritis: _____
7. Headaches: _____
8. Numbness: _____
9. Asthma: _____
10. Neuritis: _____
11. Digestive Disorders: _____
12. Nervousness: _____
13. Sinus Trouble: _____
14. Anemia: _____
15. Rheumatic Fever: _____
16. Cancer: _____

Purpose of this appointment PAIN from Auto Accident of 8/23/12
Other doctors seen for this condition _____
Have you been treated for any health condition by a physican in the last year? YES ( ) NO ( )
Describe _____
What medications or drugs are you taking? _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

HEALTH INSURANCE: YES ( ) NO ( ) COMPANY _____
Patient's Signature [signature] Date AUG 2 7 2012
Guardian's Signature Authorizing Care _____ Date _____

1. What is your major symptom? Neck pain & Low Back pain

2. If this is a reoccurrence, when was the first time you noticed this problem? NO REOCCURRENCE, 1ST TIME for these symptoms

How did it occur? from the accident

Has it become worse recently? Constant pain If yes, when and how?

3. How frequent is the condition? Constant pain

How long does it last? Constant pain

4. Are there any other conditions or symptoms you have that may be related to your major symptom? (No)

Are there other unrelated health problems? (NO)

5. If pain is involved, what type is it--sharp, dull, etc.? Sharp pain upon movement Dull pain at rest.

6. Is there anything you can do which seems to provide relief? over the counter meds help a little

7. What things seem to make the problem worse? bending, movement of hands from wrist

8. Have you had any broken bones? Yes If yes, please list them and give dates. May 1977

9. List any major accidents you have had other than those that might be mentioned above 2yrs ago Auto Accident

10. To your knowledge, have you had any diseases, major accidents, or injuries not indicated on this form either in the past or the present? No If yes, please explain:

11. WOMEN ONLY: Are you pregnant or do you feel there is any possibility you might be pregnant? DNA

12. Remarks:

SOUTH LINCOLN CHIROPRACTIC
THOMAS G. BAUER, D.C.
3201 Pioneers Blvd., Suite 32
Lincoln, NE 68502
Telephone: (402) 484-8500

SOUTH LINCOLN CHIROPRACTIC

Dr. Thomas G. Bauer

PAYMENT INFORMATION

TAX I.D. NUMBER

47-0629952

****

NPI # 1740376359

****

Patient Ledger

SOUTH LINCOLN CHIROPRACTIC

SOUTH LINCOLN CHIROPRACTIC

TROY JONES (2369)
Responsible: Self Home: (402) 416-0011
Primary: FARM BUREAU (FARMB0001) ID: 9000183596

26898	08/27/2012	0002	72010	AP/LAT FULL SPINE X-RAY	$200.00	$0.00	$200.00
26898	08/27/2012	0002	99203	INITIAL EXAMINATION	$85.00	$0.00	$285.00
26898	08/27/2012	0002	72052	SHORT DAVIS SERIES	$175.00	$0.00	$460.00
26898	08/27/2012	0002	E0230	ICE CAP OR COLLAR - (MI(	$30.00	$0.00	$490.00
26898	08/27/2012	0002	A9150	BioFreeze	$18.00	$0.00	$508.00
26898	08/27/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$558.00
26898	08/27/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$583.00
26898	08/27/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$608.00
26898	08/27/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$638.00

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:	**$638.00**	**$0.00**	**$638.00**

26900	08/28/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26900	08/28/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26900	08/28/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26900	08/28/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
26900	08/28/2012	0002	E0190	CERVICAL PILLOW - MCP	$75.00	$0.00	$205.00

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:	**$205.00**	**$0.00**	**$205.00**

26904	08/29/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26904	08/29/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26904	08/29/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26904	08/29/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:	**$130.00**	**$0.00**	**$130.00**

26915	08/30/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26915	08/30/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26915	08/30/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26915	08/30/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

Patient Ledger

SOUTH LINCOLN CHIROPRACTIC

SOUTH LINCOLN CHIROPRACTIC

TROY JONES (2369)
Responsible: Self Home: (402) 416-0011
Primary: FARM BUREAU (FARMB0001) ID: 9000183596

[redacted]

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:					$130.00	$0.00	$130.00
26919	08/31/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26919	08/31/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26919	08/31/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26919	08/31/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:					$130.00	$0.00	$130.00
26926	09/01/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26926	09/01/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26926	09/01/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26926	09/01/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:					$130.00	$0.00	$130.00
26935	09/04/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26935	09/04/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26935	09/04/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26935	09/04/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

	First Billed	Last Billed	Times Billed
Primary:	09/08/2012	09/08/2012	1

Billing Total:					$130.00	$0.00	$130.00
26945	09/05/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26945	09/05/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26945	09/05/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26945	09/05/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

Patient Ledger

SOUTH LINCOLN CHIROPRACTIC

SOUTH LINCOLN CHIROPRACTIC

TROY JONES (2369)
Responsible: Self Home: (402) 416-0011
Primary: FARM BUREAU (FARMB0001) ID: 9000183596

		First Billed	Last Billed	Times Billed
	Primary:	09/06/2012	09/06/2012	1

Billing Total:					**$130.00**	**$0.00**	**$130.00**
26953	09/06/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
26953	09/06/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
26953	09/06/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
26953	09/06/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00

		First Billed	Last Billed	Times Billed
	Primary:	09/06/2012	09/06/2012	1

Billing Total:					**$130.00**	**$0.00**	**$130.00**
27012	09/10/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27012	09/10/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27012	09/10/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27012	09/10/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27023	09/12/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27023	09/12/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27023	09/12/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27023	09/12/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27029	09/14/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27029	09/14/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27029	09/14/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27029	09/14/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27040	09/17/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27040	09/17/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27040	09/17/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27040	09/17/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27049	09/19/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27049	09/19/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27049	09/19/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00

Patient Ledger

SOUTH LINCOLN CHIROPRACTIC

SOUTH LINCOLN CHIROPRACTIC

TROY JONES (2369)
Responsible: Self Home: (402) 416-0011
Primary: FARM BUREAU (FARMB0001) ID: 9000183596

27049	09/19/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27067	09/24/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27067	09/24/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27067	09/24/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27067	09/24/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27076	09/26/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27076	09/26/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27076	09/26/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27076	09/26/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27081	09/27/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27081	09/27/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27081	09/27/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27081	09/27/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27097	10/01/2012	0002	98941	SPINAL ADJUSTMENT/3-4	$50.00	$0.00	$50.00
27097	10/01/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$75.00
27097	10/01/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$100.00
27097	10/01/2012	0002	97014	INTERFERENTIAL THERAF	$30.00	$0.00	$130.00
Billing Total:					**$130.00**	**$0.00**	**$130.00**
27103	10/03/2012	0002	72050	CERVICAL X-RAYS/4 VIEW	$132.00	$0.00	$132.00
27103	10/03/2012	0002	72100	AP/LAT LUMBAR X-RAYS	$92.00	$0.00	$224.00
27103	10/03/2012	0002	99213	ESTABLISHED RE-EXAMIN	$50.00	$0.00	$274.00
27103	10/03/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$299.00
Billing Total:					**$299.00**	**$0.00**	**$299.00**
27183	10/08/2012	0002	98940	SPINAL ADJUSTMENT/1-2	$45.00	$0.00	$45.00
27183	10/08/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$70.00
27183	10/08/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$95.00
Billing Total:					**$95.00**	**$0.00**	**$95.00**
27192	10/10/2012	0002	98940	SPINAL ADJUSTMENT/1-2	$45.00	$0.00	$45.00
27192	10/10/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$70.00
27192	10/10/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$95.00

Patient Ledger

SOUTH LINCOLN CHIROPRACTIC

SOUTH LINCOLN CHIROPRACTIC

TROY JONES (2369)
Responsible: Self Home: (402) 416-0011
Primary: FARM BUREAU (FARMB0001) ID: 9000183596

Billing Total:					**$95.00**	**$0.00**	**$95.00**
27209	10/17/2012	0002	98940	SPINAL ADJUSTMENT/1-2	$45.00	$0.00	$45.00
27209	10/17/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$70.00
27209	10/17/2012	0002	97012	CERVICAL/MECHANICAL T	$25.00	$0.00	$95.00
Billing Total:					**$95.00**	**$0.00**	**$95.00**
27220	10/22/2012	0002	99241	CONSULT 1	$65.00	$0.00	$65.00
27220	10/22/2012	0002	98940	SPINAL ADJUSTMENT/1-2	$45.00	$0.00	$110.00
27220	10/22/2012	0002	97140	TRIGGER POINT THERAPY	$25.00	$0.00	$135.00
Billing Total:					**$135.00**	**$0.00**	**$135.00**
Patient Total:					**$3,642.00**	**$0.00**	**$3,642.00**
Patient Unapplied Prepayment Total							**$0.00**
Provider Totals							
THOMAS G BAUER DC					$3,642.00	$0.00	$3,642.00
Report Totals					**$3,642.00**	**$0.00**	**$3,642.00**
Report Prepayment Totals							**$0.00**

SOUTH LINCOLN CHIROPRACTIC
THOMAS G. BAUER, D.C.
3201 Pioneers Blvd., Suite 32
Lincoln, NE 68502
Telephone: (402) 484-8500

SOUTH LINCOLN CHIROPRACTIC

DR. THOMAS G. BAUER

OFFICE CODES ON TREATMENT CARD

1. A= CERVICAL SEGMENTS 1-7
2. B= THORACIC SEGMENTS 1-12
3. C= LUMBAR SEGMENTS 1-5
4. D= HIP - LEFT OR RIGHT OR SACRUM
5. E= TTP- DOCTOR TREATED MASSAGE THERAPY
6. F= TSX- INTERSEGMENTAL THERAPY
7. G= TIF- INTERFERENTIAL THERAPY
8. G= TDT- DIATHERMY

XFS= XRAY FULL SPINE
XI0= CERVICAL XRAYS
XF2= 14X17 XRAYS
NEX= NEUROLOGICAL EXAMINATION
MCC= CERVICAL COLLAR SUPPORT
MCP= CERVICAL PILLOW SUPPORT
MICE= ICE PACKS (HOT OR COLD)
MBF= BIOFREEZE

Name JONES, TROY Date 8-27-12 Home Phone 402-416-0011

Address Work Phone

Birth Date Age Sex Marital Status Occupation Referred

MAJOR COMPLAINT & SYMPTOMS

TYPE CASE: PI

AUG 27 2012

X-RAY COMMENT

DIAGNOSIS 847.0 739.1 739.3 723.8

Seg.							Seg.
Occ.		P					Occ.
C1		C					C1
2		C					2
③	RL	C					3
④	RL	C					4
⑤	RL	C					5
⑥	RL	C					6
⑦	RL	Z					7
ⓓ1	RL	C					D1
2		C					2
3							3
4		C					4
5		C					5
6		C					6
7		C					7
8		R					8
9							9
10							10
11							11
12							12
L1							L1
2							2
3							3
4							4
⑤	Post						5
Sac							Sac
RI							RI
LI							LI
Coc							Coc
Short Leg							Short Leg

EXERCISE

DISABILITY - TOTAL From Thru

DISABILITY - PARTIAL From Thru

DIET ☐ SUPPORT ☐
VITAMINS ☐ C. PILLOW ☐
EXERCISE ☐ C. COLLAR ☐
HEEL LIFTS ☐ RELAXOBACK ☐
PT. LECT. SUPPLEMENT DATE
Mini Comm.
Pt. Call
Recommendations:

Visits	L	R	L	R	L	R	L	R	L	R
CERVICAL ROTATION										
CERVICAL FLEXION & EXT										
CERVICAL LAT FLEX										
FORAMINA COMPRESSION										
SHOULDER DEPRESSOR										
DYNAMOMETER										
WARTENBERG PINWHEEL										
REFLEX: C5 / C6 / C7 / L4 / S1										
FABERE PATRICK										
MINOR SIGN										
BILATERAL LEG RAISE										
LEG DROP TEST										
LASEGUE'S										
BRAGGARD'S										
GOLDWAITH										
SOTO HALL										
ELY'S SIGN										
ROMBERG'S										
BODY FLEXION										
BODY EXTENSION										
BODY LAT FLEXION										
KEMP TEST										
TRENDELENBERG'S TEST										

FORM NO. M-132 PROFESSIONAL PRACTICE CONTROL • 1-800-523-9682

S M
NAME JONES, TROY 402-416-0011 ACCOUNT 2369

DATE	A	B	C	D	E	F	G	
AUG 27 2012	7		5		TP	TSX		NECK PAIN LOW BACK PAIN SEE: NEX REPORT SEE: X-RAY REPORT PT ISSUED Biofreeze AND 2 FLEXERIL FOR MUSCLE PAIN. PT ENTERED MY OFFICE WITH A PAIN LEVEL OF 7. C2 THRU C7 +L5 PALPATED TIGHT & PAINFUL. ROM WAS + WITH CERVICAL AND LUMBAR REGIONS OF THE SPINE. PT ADJUSTED WELL BUT WELL. PT WAS INSTRUCTED FOR HIS TIGHT AND PAINFUL MUSCULATURE. PT WILL BE SEEN AGAIN ON 8-28-12.
AUG 28 2012	7		5		TP	TSX		PT. ENTERED MY OFFICE WITH A PAIN LEVEL OF 7+. PT. WAS ISSUED A CERVICAL PILLOW SUPPORT FOR HIS NECK AREA. THIS IS TO HELP ENHANCE HIS CERVICAL CURVATURE. PT. WAS VERY SORE TODAY. PT HAD SAME SYMPTOMS AND TREATMENT AS ON 8-27-12. PT WILL BE SEEN AGAIN ON 8-29-12.
AUG 29 2012	7		5		TP	TSX		PT ENTERED MY OFFICE WITH A PAIN LEVEL AT 7. PT HAD THE SAME SYMPTOMS AND TREATMENT AS ON 8-28-12. PT WILL BE SEEN AGAIN ON 8-30-12.
AUG 30 2012	7		5		TP	TSX		PT ENTERED MY OFFICE WITH A PAIN LEVEL OF 6-7. PT STILL WAS TENDER IN HIS SPINE. PT WAS DOING A WALKING STRETCH AS OF LAST. C3+C6 C7 AND T1 AND L5 WAS PALPATED TIGHT AND PAINFUL. PT ADJUSTED WELL BUT WELL. PT WAS INSTRUCTED FOR HIS TIGHT AND PAINFUL MUSCULATURE. PT WILL BE SEEN AGAIN ON 8-31-12.
AUG 31 2012	7		5		TP	TSX		PT ENTERED MY OFFICE WITH A PAIN LEVEL OF 6. PT HAD SAME SYMPTOMS AND TREATMENT AS ON 8-30-12. PT WILL BE SEEN AGAIN ON 9-1-12.
SEP 01 2012	7		5		TP	TSX		PT ENTERED MY OFFICE WITH A PAIN LEVEL OF 6. UPPER TRAP MUSCLES PALPATED TIGHT BILATERALLY. PT HAD ROM WAS + IN THE CERVICAL AND LUMBAR REGIONS. C3 C-7 T1 +L5 PALPATED TIGHT TODAY. PT ADJUSTED WELL. PT WAS INSTRUCTED FOR HIS TIGHT AND PAINFUL MUSCULATURE. PT STATES SHE'S FEELING BETTER LAST P.M. PT. WILL BE SEEN AGAIN ON 9-__-12.

DIG.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN.																															
FEB.																															
MAR.																															
APR.																															
MAY																															
JUN.																															
JUL.																															
AUG.																															
SEP.																															
OCT.																															
NOV.																															
DEC.																															

CASES REFERRED BY THIS PATIENT:
(Names & Dates)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

page2

NAME JONES, TROY 402-416-0011 ACCOUNT 2369

DATE	A	B	C	D	E	F	G	
SEP 04 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 5-6. Pt. had pain in his cervical and low back area. C6 C7 T1 & L5 palpated tight and tender. ROM was ↓ in the cervical & lumbar areas. Pt. adjusted well. Pt. had therapy for his tight and tender musculature. Pt. will be seen again on 9-5-12.
SEP 05 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 5. Pt. had the same symptoms and treatment as on 9-4-12. Pt. will be seen again on 9-6-12.
SEP 06 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 5. Pt. is frustrated in getting his car fixed. Pt. is stressed. ROM of the cervical and lumbar regions are ↓ today. C6 C7 T1 & L5 palpated tight and tender today. Pt. not sleeping well at night w/ pain and w/ stress. Pt. adjusted well. Pt. had therapy for his tight & tender musculature. Pt. will be seen again on 9-10-12.
SEP 10 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 5. Pt. had same symptoms and treatment as on 9-6-12. Pt. will be seen again on 9-12-12.
SEP 12 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 5. Pt. had L5 pain ↑ today. ROM was ↓ in the L5. ROM was ↓ slightly in the cervical area. C7 T1 & L5 palpated tight and tender today. Pt. adjusted well. Pt. had therapy for his tender musculature. Pt. will be seen again on 9-14-12.
SEP 14 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 4-5. Pt. had tight traps upon palpation, bilaterally. C3 & C5 palpated tight today. Pt. had therapy for his tight musculature. Pt. will be seen again on 9-17-12.
SEP 17 2012	7	1	✓		TR	TSX	FE	Pt. entered my office with a pain level of 4. Pt. had the same symptoms and treatment as on 9-14-12.

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CASES REFERRED BY THIS PATIENT:
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NAME PAGE3 JONES, TROY 402-416-0011 ACCOUNT 2369

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DATE	A	B	C	D	E	F	G	
SEP 17 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of [illegible]. Pt will be seen again on 9-19-12
SEP 19 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of 5. Pt's complaints are 4 in the cervical and lumbar regions of his body. C7 + L5 palpated tight and tender. Pt's sleeping fine now. Pt adjusted well today. Pt had [illegible] for his tight and tender muscles. Pt will be seen again on 9-24-12
SEP 24 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of 4. Pt had same symptoms and treatment as on 9-19-12. Pt will be seen again on 9-26-12.
SEP 26 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of 4. Pt had same symptoms and treatment as on 9-24-12. Pt will be seen again on 9-27-12
SEP 27 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of 4. Pt had [illegible] pain [illegible] cervical [illegible] region. C7 [illegible] L5 palpated tight and tender today. Pt [illegible] for his tender muscles. Pt will be seen again on 10-1-12
OCT 01 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of 3. Pt had the same symptoms and treatment as on 9-27-12. Pt will be seen again on 10-3-12
OCT 03 2012	97	1	5		TR	TX	FEE	Pt entered my office with a pain level of 3. Pt is having an update today. X10(4) XF2(2) AP+Lat Lumbar C-Neck. Pt will be seen again on 10-8-12
OCT 08 2012	97		5		TR	TSN	–	Pt entered my office with a pain level of 1. Pt had treatment & reports today. C7 + L5 palpated tight & tender. Pt had [illegible] for tight muscles. Pt will be seen again on 10-10-12

MO.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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PAGE4 JONES, TROY 402-416-0011 ACCOUNT 2369

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OCT 1 0 2012	2		5		[illegible]	TA	-	Pt entered my office with a pain level of 1. Pt's mid cervical region was [illegible] in the ROM of the cervical spine. Pt adjusted well. Pt was [illegible] for [illegible] musculature. Pt will be seen again on 10-17-12.
OCT 1 7 2012	2				[illegible]	TA	-	Pt entered my office with a pain level of 0. Pt had some [illegible] since 10-10-12. Pt will be seen again on 10-22-12. Barring any exacerbation of his condition Pt will be released from care at that time.
OCT 2 2 2012	2				[illegible]	-	-	Pt entered my office with a pain level of 0. Pt had an [illegible] regarding [illegible] the cervical curvature. Pt had a consultation on how to care for himself post treatment. Pt has reached maximum medical improvement. Pt's released from care as of today.

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Providing Insurance and Financial Services
Home Office, Bloomington, IL

State Farm™

September 26, 2012

Troy Jones
4820 Sherman St
Lincoln NE 68506-3960

State Farm Claims
PO Box 52273
Phoenix AZ 85072-2273

RE: Claim Number: 27-10X4-944
Date of Loss: August 23, 2012
Our Insured: John E Hesser
Claimant Name: Troy Jones

Dear Mr. Jones:

We have been unable to contact you concerning your auto claim. Please contact us as soon as possible.

We can normally be reached between 8:00am to 4:30pm Monday through Friday. All times are Central Standard Time.

Thank you for your cooperation. We look forward to hearing from you.

Sincerely,

Laura Tague

Laura Tague
Claim Representative
(800) 889-7144 Ext. 5975557
Fax: (800) 423-0474

State Farm Mutual Automobile Insurance Company

Enclosure: none